NEWS LETTER FROM KIYOSE

The Research Institute of Tuberculosis, JATA
3-1-24 Matsuyama, Kiyose-shi, Tokyo 204-8533, Japan

No.40, March 2025

-Letter from the Director-

Strategies toward TB Elimination

Seiya Kato,
Director

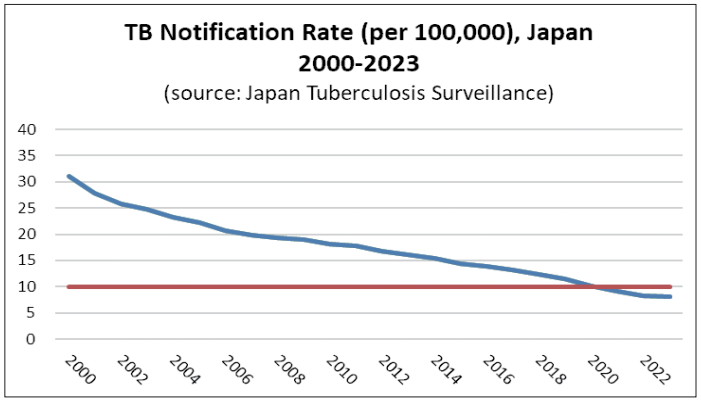
Japan became a low TB incidence country in 2021. In 2022, TB incidence of tuberculosis decreased by more than 10% to be 8.2 per 100,000 population. During the COVID-19 pandemic TB notifications decreased by more than before. However, the decrease in TB incidence in 2023 was only 1.4%. due to an increase in foreign-born patients as restrictions on international movement of people were restored. The proportion of foreign-born patients was 16%, particularly for those in their 20s for whom it was around 85%. It is highly likely that the proportion of foreign-born patients will increase because under the circumstances of Japan's low birth rate and super-aging society, young workers from neighboring countries are essential for the maintenance of our society. Thus, TB control among foreign-born is important for TB elimination, the next and ultimate goal in Japan.

The Japanese government will initiate pre-entry TB screening for immigrants from the top six countries with the highest number of TB cases in Japan, namely, the Philippines, Vietnam, Indonesia, Nepal, Myanmar, and China. Post-entry screening is also important because a certain number of foreign-born patients develop the disease after entering Japan. For early detection of symptomatic patients, information on costs and procedures for consultation at medical facilities should be properly provided. All diagnosed TB patients should be provided with adequate patient-centered support for completion of treatment in Japan so that they can pursue their dreams and hopes by living in Japan. However, if a patient needs to return to his or her home country for special reasons, he or she should be referred to a medical facility that is appropriate for the patient's destination.

RIT/JATA started a new project to support the referral of such TB patients. Based on the request from the public health center, RIT finds a suitable medical facility and coordinates the referral of the patient. RIT guides the patient to visit the referred medical facility in cooperation with the health center. At the end, RIT tries to confirm whether the first visit was made or not after the patient's return. In the future, an official referral system to all countries concerned is expected to be set up.

Most importantly, it is hoped that progress in TB control in high-prevalence countries will lead to a reduction in the global risk of TB infection.

We will further strengthen the global TB control effort as follows. In the context of global economic growth, high prevalence countries are moving from a developing to middle income status. It may happen that innovative technologies for TB control are deployed in high prevalence countries and put to practical use more rapidly than in developed countries. Therefore, it is necessary to move beyond the traditional relationship of technology transfer and promote collaboration as a partner in jointly developing and applying new technologies utilizing various funding sources. RIT is looking forward to more opportunities to contribute to the End TB Strategy.



Dr. Akihiro Seita is awarded the Yomiuri Prize for Health Care Work

We are pleased to inform you that Dr. Akihiro Seita, who has worked for more than 30 years to provide health care for people mainly in the Middle East, especially Palestinian refugees, received the 31st Yomiuri International Cooperation Prize (https://japannews.yomiuri.co.jp/society/general-news/20241126-224590/). Dr Seita worked in Department of International Cooperation, the Research Institute of Tuberculosis, JATA from 1987 to 1995. After that, he worked as the person responsible for the AIDS, Tuberculosis and Malaria programme at the World Health Organization Regional Office for the Eastern Mediterranean, where he made great efforts to introduce and expand DOTS in the region. He is currently Director of Health at the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), where he oversees the medical and health care of some 5.9 million refugees. In November 2024, a meeting was held at the JATA headquarters to hear his lecture. Dr Seita wrote the article titled "All We Need to Know in Public Health, We can Learn from Tuberculosis Care" in Issue No 30 of this Newsletter in 2015. He mentioned this message also in his lecture. We would like to make the article accessible on our website.

(Newsletter From Kiyose. No. 30. 2015)

All We Need to Know in Public Health, We can Learn from Tuberculosis Care

Akihiro Seita,
Director of Health
UNRWA (United Nations Relief and Works Agency for Palestine Refugees in the Near East)
Headquarters, Amman, Jordan

Report from RIT/JATA project: Research on Factors Associated with Favorable Tuberculosis Treatment Outcomes Determined Using Multiple Regression Analysis in Lusaka, Zambia, 2022

Masaki Ota, RIT/JATA

RIT/JATA has been implementing the project to strengthen the TB programme in Lusaka, Zambia since 2008. I am the focal point of this project in RIT/JATA. Operational research has been also conducted as a part of the project activities in partnership with the National Tuberculosis and Leprosy Control Programme, Zambia. In this issue, I would like to introduce the research aiming to identify the factors associated with favorable treatment outcomes of tuberculosis patients with TB registered at two hospitals and two urban health centres in Lusaka, Zambia in 2022, about which an article was recently published (Daka, Samuel, Ota Masaki, Samungole, Graham K. International journal of Mycobacteriology 13(4):p 362–368, Oct-Dec 2024). Samuel Daka is a staff member of JATA, Zambia and Graham K Samungole is TB Officer, National Tuberculosis and Leprosy Control Programme, Ministry of Health, Lusaka, Zambia.

This was a retrospective cohort study. We classified outcomes into two categories: favorable outcomes (cure and treatment completion) and unfavorable outcomes (loss to follow-up, death, failure, and not evaluated), and identified factors associated with these outcomes using multivariable regression analysis. We included only factors obtained from the tuberculosis register at the diagnostic facility as independent factors, and did not directly interview the patients.

A total of 2945 TB patients were included in the study. 2071 (70.3%) were male and 1346 (45.7%) had bacteriologically positive pulmonary TB. The overall treatment success rate was 88.2%. I would like to describe the results of the multivariable regression analysis. Patients with contact details such as telephone numbers recorded in the register were 2.16 times (95% confidence interval [CI]: 1.30–3.61) more likely to achieve favorable treatment outcomes compared to those without. On the other hand, as the age of the patient increased by 1 year, the likelihood of achieving favorable treatment outcomes decreased to 0.99 (95% CI: 0.98–1.00). Patients with unknown HIV status were 0.0079 times (95% CI: 0.0024–0.0259) more likely to have a favorable treatment outcome compared to those who were HIV negative. This means they are 127 times more likely to have an unfavourable treatment outcomes than those who were HIV-negative. In addition, patients registered at treatment facilities A and B were 4.8 times (95% CI: 2.7–8.4) and 1.8 times (95% CI: 1.1–3.0), respectively, more likely to have favourable outcomes compared to those registered at the diagnostic facility D.

This study included approximately 1/20 of all patients with TB registered in Zambia and the multivariable regression analysis was performed using the information from the TB registers. Previous studies have also shown a tendency for unfavorable treatment outcomes in patients who are older, who have not had an HIV test, and who do not have contact information listed in the registry. Diagnostic Facility D is located in a poor area, and many homeless people are registered there, and it is thought that this situation caused the lower rate of favourable treatment outcomes. This study might suggest that healthcare providers should prioritize collecting contact details and testing HIV, especially in older adults with presumptive TB. Early diagnosis and proactive management strategies are essential for improving treatment outcomes. While the information to be analyzed is limited in this type

of study because of using only information recorded in the TB registers, we may find factors which require attention for improving TB care by using regularly available information.

Report on JICA activities in the Philippines ~Tuberculosis screening using new technology~

Tetsuhiro Sugamoto, RIT/JATA

Last year, I reported on the implementation of TB screening at the Muntinlupa Health Centre. The conventional protocol had been to suspect as presumptive TB cases those with cough lasting more than two weeks, The suspected cases are first subjected to Xpert sputum tests and proceeded to chest X-ray (CXR) test only if the sputum test was negative. However, with the introduction of digital CXR equipment and AI-Computer Aided Detection (CAD) technology, we modified this approach by recommending CXR screening for all patients who had not been tested within the past 6 months, regardless of respiratory symptoms. CAD was implemented to enhance TB detection accuracy and streamline diagnostic workflows while addressing the shortage of radiographers. This new screening strategy proved effective, as it identified more TB cases that would have been missed under the conventional symptom-based screening approach, demonstrating the effectiveness of CXR screening. This report presents detailed results of this Japan International Cooperation Agency (JICA)'s activity as a then-JICA expert.

Health check-up results:

As shown in figure 1, during the period of November 21, 2022 - May 20, 2023 (6 months), of the 1,626 health center visitors, 1,582 (97.3%) were included in the analysis, excluding 44 who had already undergone a chest X-ray at another facility or were registered as duplicates. Of these, 63% (993) were women, approximately 23% (362) were aged 65 years or older and 39% (623) lived in economically depressed areas. In addition, approximately 85% (1,337) of those examined had no TB symptoms and a further 1,409 had not had a chest X-ray examination within the previous six months. Finally, 32.6% (481) underwent a chest X-ray examination and CAD assessment. Of these, 382 were determined by CAD to be suggestive of TB. Of these 382, 120 (31.4%) underwent GeneXpert testing, resulting in 21 being positive for TB. Ultimately, 24 were bacteriologically and clinically diagnosed with TB, with the majority tending to be male, which was consistent with previous national TB prevalence survey results. Among others, patients with symptoms lasting longer than two weeks were more likely to be bacteriologically positive, particularly those living in deprived areas, who tended to have more severe symptoms upon visiting a health center. It is suggested that this may be due to the behavioral characteristics of patients, whereby they take action to seek medical attention following a worsening of symptoms. These results reaffirm that patient gender, duration of symptoms, and area of residence influence the diagnosis and treatment of TB.

Discussion and recommendations:

Regarding the participation in check-ups, it was found that there was a gap between the number of X-ray and GeneXpert tests, with uptake rates of 32.6.% and 31.4% respectively. A statistical analysis of this difference in relation to the distribution of patients according to the presence or absence of TB symptoms and demographics (gender, age and residential area) indicated that there were significant differences based on gender and residential area.

Specifically, it was suggested that women were more likely to participate and that patients from deprived areas were more likely to refuse testing. This may be due to the cost of testing, time required for testing, stigma of TB and lack of knowledge about TB.

A possible response to this is to raise awareness and knowledge among the population through subsidizing the cost of testing for patients with financial problems, and TB education, which in turn reduces stigma in society. There was also a significant difference between CAD score and GeneXpert testing uptake, with patients with a CAD score of 50 or above showing a tendency to take the Xpert test. It is suggested that this may be due to a bias in the advice by the physician, resulting in a reduced risk of missing the test for patients.

Interviews also revealed that the difficulty of sputum collection, the inconvenience of revisiting the health center, the burden of transport costs, stigma, and the minor nature of symptoms impacted the low uptake rate of GeneXpert test. Based on these results, immediate sputum collection in the health center when TB is suspected during CAD assessment could be an effective way to increase uptake. Not only does this eliminate the need for a return visit, thereby reducing the burden on the patient in terms of inconvenience and transport costs, but it is also expected to enable earlier treatment through earlier diagnosis.
The project aimed to efficiently detect TB patients by utilizing digital CXR with CAD as an intensified case finding (ICF), in addition to the conventional passive case finding (PCF), in which TB screening is conducted using some method even for those who have no symptoms. As a result, it became clear that ICF could detect more TB patients at an earlier stage compared

to PCF (Figure 2). This emphasizes the need to strengthen finding TB patients and provide early intervention, regardless of whether they have TB symptoms or not. Furthermore, early and efficient detection of TB cases could also prevent the spread of infection.

Regarding the use of CAD, when the default CAD threshold value of 15 set by the manufacturer was used, it indicated an increased risk of over-diagnosis and the associated increase in laboratory workload in this project. Therefore, adjusting the threshold according to the conditions of the subjects to which CAD is applied while suppressing overdiagnosis and reducing laboratory workload is being considered for the future.

Summary:

In the JICA project activity in which I was engaged, a new approach to enhancing the detection of TB patients using digital CXR with CAD was tested at the Putatan Health Centre in Muntinlupa. The need for TB screening of asymptomatic persons, which was reaffirmed in this initiative, contributes to the early detection of TB cases and the introduction of CAD has the potential to reduce the human resource burden. However, some issues for future improvement in the use of CAD were also highlighted, such as setting appropriate thresholds, being aware of the risk of false positives and false negatives, and close collaboration with the reading physician. The project reaffirmed the need for financial support to increase the participation rate and the reduction of stigma in society through TB education. It is important to continue to accumulate evidence to support the effectiveness of digital CXR with CAD and to utilize CAD through TB screening activities and research studies. This JICA activity was presented by our counterpart Dr. Leonor S. Tubon (Medical officer, City Health Office of Muntinlupa) at The 9th Asia Pacific Region Conference of the International Union Against Tuberculosis and Lung Disease (APRC2024) held in Taipei, Taiwan from April 26 to 29, 2024. The presentation highlighted the results achieved through the introduction of digital CXR and CAD technology and discussed challenges to enhance TB case detection in the Philippines. After JICA's support has ended, the City of Muntinlupa City Health Office and Fujifilm Corporation will continue to cooperate and promote TB control in the Philippines through CXR with CAD-based TB screening. The agreement is to promote TB control in the Philippines through CXR with CAD-based TB screening.

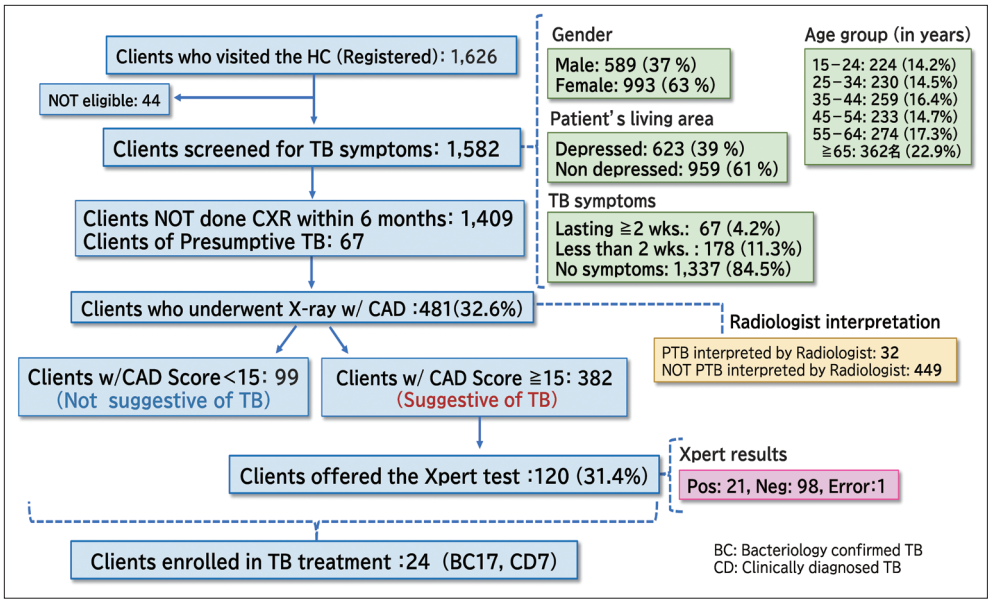


Figure1. Outline of Result

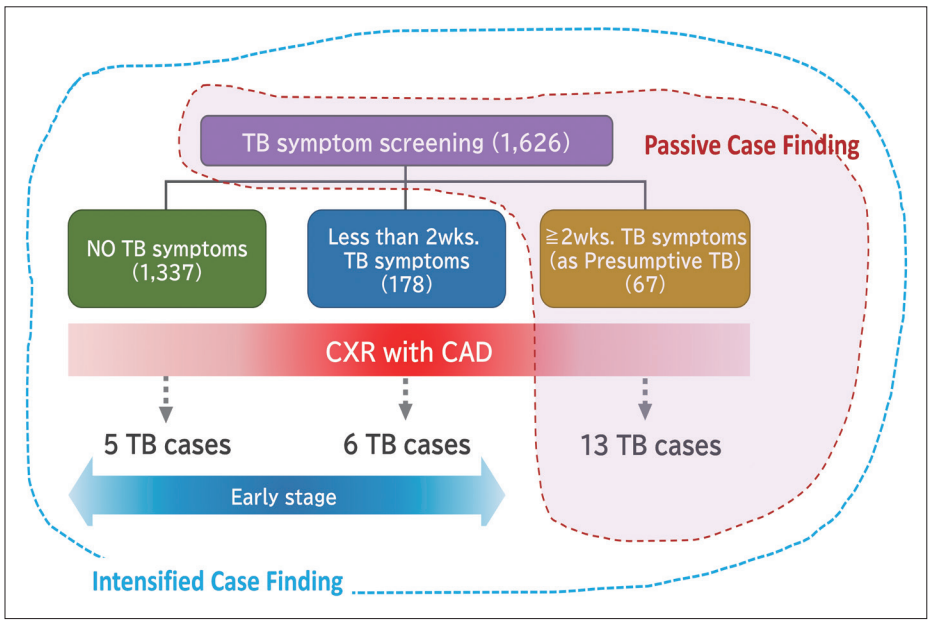


Figure 2. Early Detection via facility-based ICF

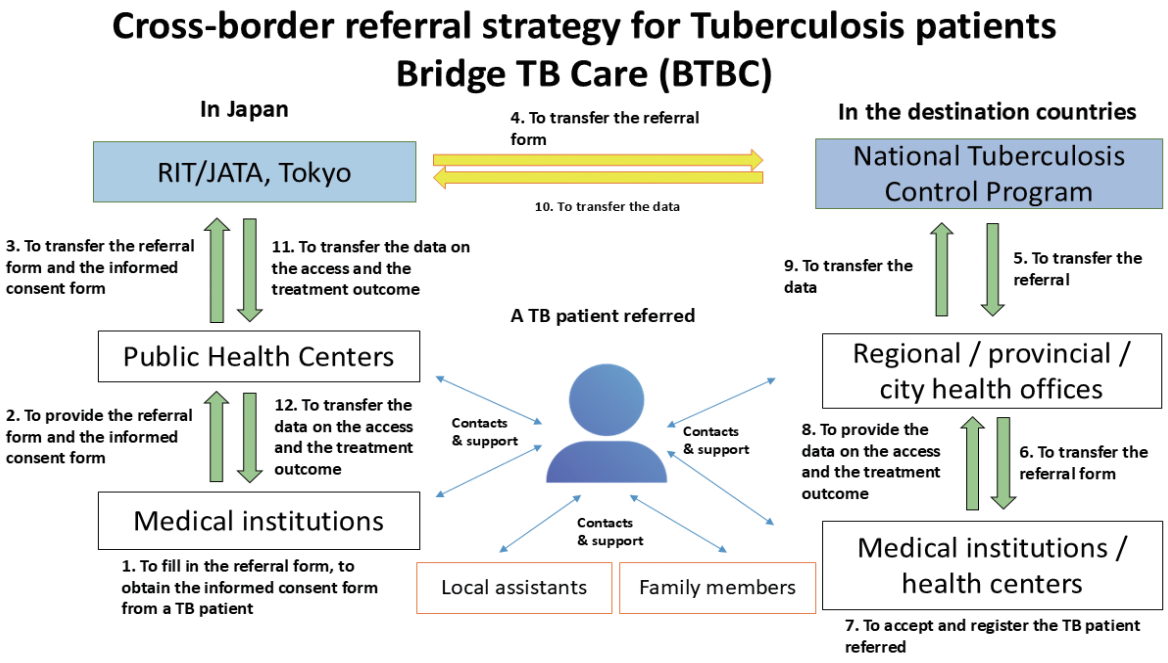
Acknowledgment:

The success of this work was made possible by the active cooperation of the staff of the Muntinlupa City Health Department (CHO), the Putatan Health Center and the Philippine Department of Health (DOH), as well as dedicated logistical support from the JICA Philippines Office and JICA Headquarters, and back-up from the Japan Anti Tuberculosis Association (JATA) and the Research Institute of Tuberculosis (RIT). The cooperation and dedication of Ms. Auwie Querri, the technical assistant who worked with me, and all the stakeholders was essential. Without your support I could not have achieved so much. I will continue to strive to contribute towards the eradication of TB in the Philippines. Thank you so much to everyone for your support.

Report on Research on a Cross-border Referral Strategy

Akihiro Ohkado, RIT/JATA

In Japan, the number of foreign-born people and the proportion of foreign-born people among registered patients are increasing, especially among young people. (In 2023, 1,619 (16.0%) of the 10,096 newly registered patients were foreign-born across all age groups, but in the 20-29 age group, that proportion was 84.8%). It also has been recognized that the proportion of transferred-out as the treatment outcome is high among foreign-born TB patients (about 9% of foreign-born TB patients registered in 2022). Since it is necessary to complete TB treatment, it is recommended to establish a support system to access TB treatment services for these individuals after they return to their home countries. We conducted a study on the cross-border referral strategy for patients with TB, which we called 'Bridge TB Care (BTBC)'. The article on this study was published (Ohkado et al. Ensuring continuous TB treatment across Asian borders. Public Health Action. 2024 Mar 1;14(1):20-25). We will report the outline and overall results here.



This study aimed to describe the results of the Bridge TB Care (BTBC) initiative of the Research Institute of Tuberculosis (RIT) in Tokyo, Japan, to ensure access to healthcare services and to enable sharing of the treatment outcomes of patients with TB who are transferred abroad.

This study included all overseas-born patients who were diagnosed with active TB in Japan from August 2019 to July 2023 who were willing to or decided to return to their home countries during treatment, and who provided informed consent. We included these people as a cohort group and observed them towards the end of the TB treatment course. The referral strategy, BTBC, is shown in the figure. The public health centres that provided care to patients with TB in Japan initially contacted the RIT and sent a patient referral form and informed consent form to the RIT. Subsequently, the RIT contacted the relevant NTP staff members in the destination country and then the engaged NTP staff identified a suitable health facility to be accessed by the patient upon return. In collaboration with local assistants assigned by the RIT, RIT staff collected information about the patients' healthcare access and treatment outcomes. The RIT staff and the local assistants communicated with patients with TB via social networking services (SNS) so that they could assist patients and monitor their treatment status in their home countries.

We used two indicators for patients with TB in this programme: 1) access rate (AR, %) = [number of referred patients with TB who accessed healthcare facilities in their home countries] / [number of referred patients with TB from Japan]; and 2) TB treatment success rate (SR, %) = [number of referred patients with TB who successfully completed treatment in their home countries as of July 2023] / [number of referred patients with TB from Japan who were due for TB treatment completion as of July 2023].

From August 2019 to July 2023, 135 foreign-born TB patients were enrolled in the study. The main destination countries were Vietnam (35 patients), the Philippines (28 patients), Indonesia (26 patients), and China (16 patients). We confirmed that 112 of the 135 patients enrolled were successfully referred to a health facility after returning to their home countries: the access rate was 83%. 102 of the 135 patients were due for treatment completion as of the end of July 2023. Of these, we were able to confirm that 87 patients had successfully completed their TB treatment; the SR was 85.3%. Of the 87 patients, 49 (56.3%) had their treatment outcome confirmed using official information or clinical reports. Treatment outcomes were confirmed in the remaining patients through self-reports or reports from relatives. We did not identify significant differences in the treatment success rate based upon patient characteristics, except between the patients with confirmed access to a healthcare facility and those without (P = 0.001).

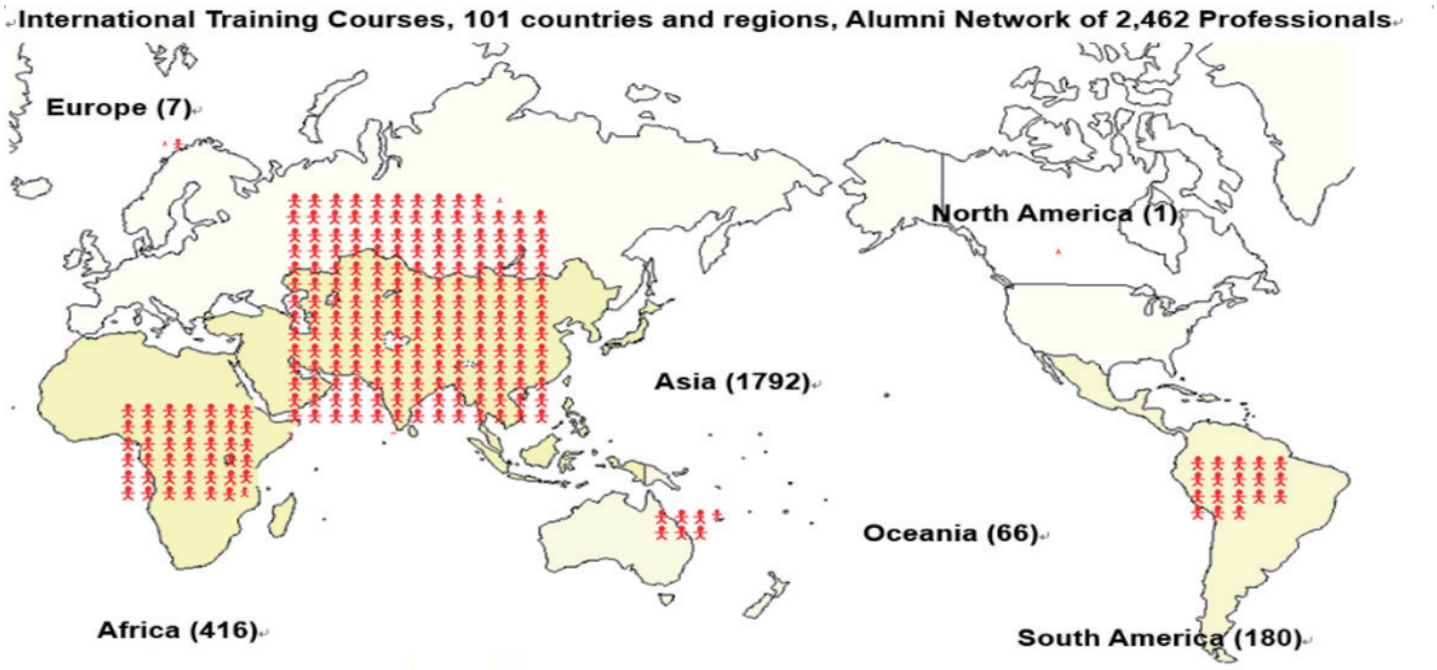
The full text of this paper can be accessed at: https://pmc.ncbi.nlm.nih.gov/articles/PMC11122705/.

The New JICA Training Courses Will Begin.

The JICA training courses, which began in 1963, have been revised to incorporate the latest tuberculosis control measures and techniques. We are pleased to announce that the following two training courses will be held in 2025.

- For persons engaged in the infectious disease laboratory: Frontline Defense: Managing Outbreaks and Laboratory Network
- For persons engaged in infectious disease control programmes: Innovations in Infectious Disease Control : Pandemic Prevention, Preparedness and Response (PPPR)

These training courses aim to strengthen infectious disease control measures for responding to outbreaks and for PPPR as well as strengthening TB control. We believe that the experiences of the TB control programme can contribute to the strengthening of infectious disease control and the laboratory network which can function well for outbreak response and PPPR. These experiences include strengthening of the laboratory network, HSS through UHC, PPM and community participation, new technologies for pathogen and mutation detection such as rapid molecular diagnostic and NGS, new technologies that are useful for diagnosis, such as chest X-ray with CAD, and remote patient support using IT. As the issues covered by this training are new, we would like to emphasize not only the acquisition of knowledge related to them, but also the sharing of experience among the participants and lecturers. The training will be conducted in a combination of online training and training on site in Japan, taking into account the convenience of the participants.



※The names of countries and regions are at the time of training participation.
The Research Institute of Tuberculosis, JATA
(1963 – OCT 2023)

Voice from a participant of JICA Training Course 2024

Chutima Siripanumas
Division of Tuberculosis, Department of Disease, Control, Ministry of Public Health, Thailand

I recently had the opportunity to meet Dr. Norio Yamada and Dr. Ikushi Onozaki in Bangkok, Thailand. They visited the Division of Tuberculosis to assist the NTP Thailand in preparing the 5th prevalence survey. Meeting again with Dr. Yamada and Dr. Onozaki brought back many good memories from Kiyose.

Last June, I had the opportunity to participate in the JICA Knowledge Co-Creation Program on Ending TB and Responding to Health Emergencies (Innovation in Health System Development) at RIT, alongside co-participants from various countries, including Egypt, Eritrea, Papua New Guinea, Thailand, Timor-Leste, Myanmar, China, and Japan. Throughout the 7-week course, we explored a wide range of topics, including epidemiology and public health. We gained in-depth knowledge about various aspects of TB, from case finding and detection to treatment, preventive therapy, and the utilization of laboratory services and CAD X-ray to aid in TB detection. One of the topics that particularly resonated with me was the importance of community involvement and multisectoral accountability,

which are essential for the success and sustainability of TB programs.

The program not only provided valuable insights from experts and experienced professionals but also fostered an environment for participants to share knowledge and experiences. We learned a lot from our co-participants, as each country shares their knowledge and interventions in TB control. Learning from the successes of others has provided valuable guidance for the way forward, while reflecting on challenges and mistakes has helped us plan more carefully for potential obstacles in the future.

The training broadened our perspective, enhancing both our knowledge and experiences. It emphasized the importance of collaboration across various sectors and regions, highlighting how crucial it is for us to work together to end TB.

Prof. Nguyen Viet Nhung received the Princess Chichibu Memorial Global TB Award

We are pleased to inform you that the winner of the Princess Chichibu Memorial TB Global Award for 2024 is Prof. Nguyen Viet Nhung. Prof. Nguyen Viet Nhung is the Director of the National Lung Hospital, the Director of the National Tuberculosis Program, the President of the Vietnam Lung Association and the Head of the Faculty of TB and Lung Diseases at Hanoi Medical University. Dr Seiya Kato, Director, RIT/JATA, presented the award to Prof. Nguyen Viet Nhung for his outstanding contribution to Vietnam and global TB control and prevention on behalf of Her Imperial Crown Highness Princess Akishino, Patroness of the Japan Anti-Tuberculosis Association on the occasion of the Union World Conference on Lung Health in Bali, Indonesia in November 2024.

Her Imperial Highness Princess Chichibu has been the patroness of JATA from its foundation in 1939. Shortly after she started to serve as patroness, her husband, Prince Chichibu, a Great-uncle of the current emperor, suffered from tuberculosis and passed away after a more than 10 year battle with the disease. Upon this sad experience, Princess Chichibu devoted herself throughout her life to the prevention of TB. This award was initiated to commemorate her will to make the world free from TB.

Workshop “Strengthening TB Diagnostics in the Western Pacific Region”

The workshop entitled Strengthening TB diagnostics in the Western Pacific Region was organized to update participants on the latest WHO guidelines and standards for TB diagnosis, discuss country findings, and develop action plans. The workshop took place from 16 April – 18 April 2024, working with WPRO as a part of our collaboration with WHO. The workshop brought together more than 58 participants, including NTP managers and laboratory staff from seven priority countries (China, Cambodia, Laos, Mongolia, Papua New Guinea, Philippines, and Vietnam), representatives from 4 Supra National Reference Laboratories (SRLs) (Queensland, Hong Kong, Korea, and Japan), partner agencies (SmartSpot, Cepheid, Genoscreen, Tauns), WHO Western Pacific Regional Office and Headquarters representatives, and local observers. This workshop aims to bring together diverse stakeholders, including healthcare professionals, laboratory experts, policymakers, researchers, and representatives from affected communities, to collaboratively explore, discuss, and strategize the way forward. The workshop provided a platform for countries to share experiences, learn from each other, and develop targeted integrated plans to strengthen their TB diagnostic networks in line with WHO guidelines and best practices. Although the workshop will focus on TB diagnosis and laboratory services, it will use an integrated systems approach to strengthen access to laboratory services, particularly at the primary healthcare level. The countries developed plans to scale up rapid diagnostics and strengthen laboratory systems, focusing on expanding new technologies, improving sample transportation, and building capacity for advanced testing methods, while also identifying challenges such as funding, human resources, infrastructure, and procurement delays.

(Group photo: under the cherry blossom tree in full bloom at RIT)

Other News

Visit to the Bureau of TB (BTB), Thailand

A prevalence survey has been planned in Thailand. RIT has been engaged in technical assistance for developing the survey protocol. In January 2025, Dr Onozaki, Dr Yamada and Dr Yanai, RIT/JATA, attended the meeting on the prevalence survey. In the meeting, we met the ex-participants of JICA training courses who are engaged in the prevalence survey.

Visit to National Center for Communicable Diseases (NCCD), Mongolia

In February 2025, Dr Okada and Dr Yamada visited the National Center for Communicable Diseases (NCCD), Mongolia to discuss future possible collaborating activities between NCCD and RIT/JATA activities, such as strengthening case detection.

Introduction of Centre for JPETS Quality Assessment

The Centre for Japan Pre-Entry Tuberculosis Screening (JPETS) Quality Assessment was established in April 2020, to assist the Ministry of Health, Welfare and Labour, Japan in operating Japan's pre-entry tuberculosis screening programme. The Centre has been contributing to the development of JPETS and quality assurance of pre-entry TB screening in China, Indonesia, Myanmar, Nepal, the Philippines and Viet Nam. Please visit the website: https://jata.or.jp/english/outline/organization/jpets/ for further information. The Ministry of Health, Labour and Welfare, Japan, has announced that the JPETS will commence in 2025. JPETS will be introduced to three countries (the Philippines and Nepal from March, Viet Nam from May) where all necessary coordination has been completed out of the 6 counties. Please visit the website:
https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/kenkou_iryou/kenkou/kekkaku-kansenshou03/english.html for information on JPETS.

Student Late-breaker Session in The World Conference on Lung Health, supported by RIT/JATA

Since 2017, RIT/JATA have been supporting the Student Late-breaker session which aims at promoting young researchers in the field of TB and related factors in the World Conference on Lung Health. Support for travel and registration is provided for several students, whose abstracts are selected by the review committee from L&MICs. The announcement will be provided on the website of The Union.

Message from Editor

We are now basically not sending hard copies by postal mail, but this "NEWSLETTER FROM KIYOSE" No.40 can also be reviewed at the following links:
English: https://jata.or.jp/english/outline/organization/centre/
Japanese: https://jata.or.jp/outline/organization/international/
Please send us your messages and updated contact information to; newsletter@jata.or.jp or you could fax to: +81-42-492-4600

We are pleased to inform you that our web site has been revised. We hope the new web site is user-friendly and will provide useful information. Please visit it and share your suggestion for further improvement of the web site.

Staff Transitions:

Newly joined RIT/JATA:
Dr. Yuka Nagata

Left RIT/JATA:
Ms. Naoko Nagata

You are welcome to send us your news and voices!

NEWS LETTER FROM KIYOSE

Publisher: S. Kato, Director
Editor: N.Yamada

The Research Institute of Tuberculosis (RIT)
Japan Anti-Tuberculosis Association (JATA)
3-1-24 Matsuyama, Kiyose-shi, Tokyo 204-8533, Japan
Phone:+81-42-493-5711 Fax:+81-42-492-4600
E-mail:newsletter@jata.or.jp
Website:https://www.jata.or.jp/english/